Department of
Mental Health &
Substance Abuse Services

DRAFT

FY 2018 - 2019
Substance Abuse Prevention and Treatment Block Grant

Behavioral Health Assessment and Plan

Strengths and Organizational Capacity of the Service System

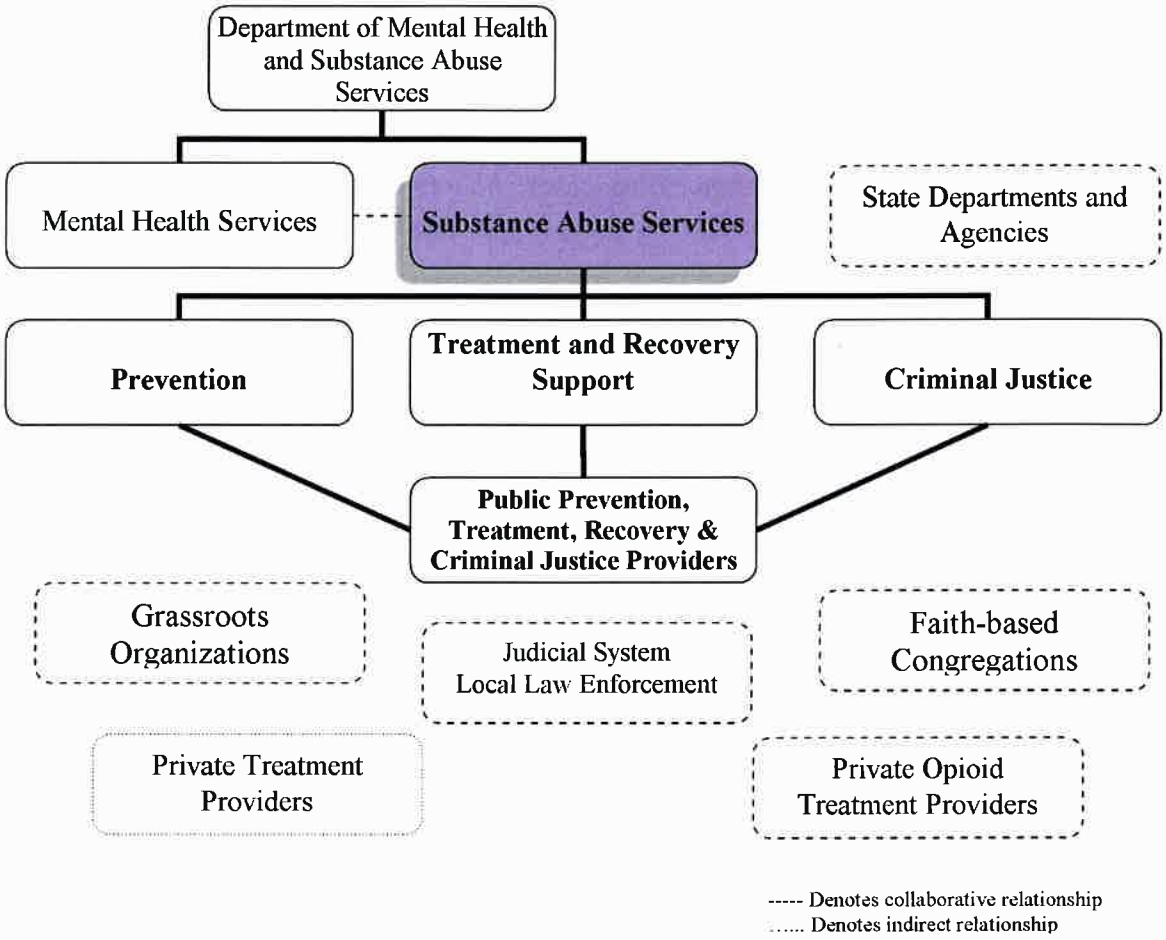
Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the five criteria that must be addressed in state mental health plans. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

The Department of Mental Health and Substance Abuse Services (TDMHSAS) serves as Tennessee's substance use disorders, mental health and opioid authority. The Department is responsible for system planning; setting policy and quality standards; licensing personal support services agencies, substance abuse and mental health services and facilities; system monitoring and evaluation; and disseminating public information and advocacy for persons of all ages who have a substance use, mental or co-occurring disorder, including serious emotional disturbance. TDMHSAS also provides inpatient psychiatric services for adults, including acute, subacute, and secure forensic beds, through its operation of five fully accredited Regional Mental Health Institutes (RMHIs). Listed below and hereafter is Tennessee's substance abuse system.

Tennessee's Behavioral Health Substance Abuse System

Substance abuse is a pervasive public health issue. It has roots in individual, family, peer, and community conditions that shape risk for experiencing substance abuse and its consequences. It negatively impacts families and children; increases crime and threatens public safety; and imposes tremendous social and economic cost to society. Not surprisingly, these pervasive social manifestations prompt responses across our public and private institutional systems. While it is difficult to paint a precise picture of the entire system for serving individuals experiencing substance abuse and its consequences, the information below helps to establish the parameters of the role currently played by TDMHSAS, Division of Substance Abuse Services (DSAS) within the entire state system. Understanding the context of this information is important for making realistic strategic decisions about how DSAS' role may be defined more effectively in the future, and how that role may be coordinated with other components of the full system of service for substance abuse and related problems.

Tennessee Behavioral Health Substance Abuse System



The ***Division of Substance Abuse Services*** serves as the Single State Authority (SSA) for receiving and administering federal block grant and state funding for substance abuse services. Our mission is to improve the quality of life of Tennessee citizens by providing an integrated network of comprehensive substance use disorders services, fostering self-sufficiency and protecting those who are at risk of substance abuse, dependence and addiction. One of ***DSAS' strengths*** is its' integrated behavioral health substance abuse system. This system consists of: providers, state departments, state agencies, judicial courts, grassroots organizations and faith-based organizations that are collaborating to provide an effective and efficient delivery of mental health and substance abuse services to Tennesseans.

According to the National Survey of Substance Abuse Treatment Services (N-SSATS), in 2016, the overall Tennessee treatment system included 227 facilities which is an increase from 2011 (208). 66% were private non-profit facilities and 31% were private for-profit agencies. ***DSAS***

purchases services directly from non-profit and for-profit providers; and have established a partnership that is transparent and respectful.

Profile of Tennessee Treatment Facilities

Type of Facility	Number of Facilities	Total Number of Clients
Private non-Profit	150	6,772
	66%	48%
Private for-Profit	71	7,031
	31%	50%
Public	6	276
	3%	2%
Total	227	14,079
	100%	100%

DSAS works closely with its' Sister Division, ***Mental Health Services***. The Divisions are collaborating to ensure that all contracted agencies provide co-occurring mental health and substance abuse services; peer recovery specialists are trained on working with faith-based communities and the criminal justice population; and diversion strategies to help prevent individuals from re-entry into and or out of jail or prison.

Through TDMHSAS, Office of Licensure, DSAS assisted with promulgating rules and developing policies for ***private and public substance abuse treatment agencies***. While DSAS does not fund ***Opioid Treatment Providers***, we are responsible for the oversight of Tennessee's opioid treatment programs. The State Opioid Treatment Authority (SOTA) provides administrative, medical, and pharmaceutical oversight to certified opioid treatment programs, including, but not limited to planning, developing, educating, and implementing policies and procedures to ensure that opioid addiction treatment is provided at an optimal level. The SOTA is also responsible for promulgating rules for Office-based Opioid Treatment providers that have one hundred-fifty patients on buprenorphine products.

DSAS has forged vital relationships with other ***state departments and agencies*** to improve coordination of care for individuals with substance abuse disorders. Formal partnerships have been established with the Departments of Agriculture, Correction and Health; and Tennessee Bureau of Investigation. These partnerships allows for data sharing, prevention education and treatment services. DSAS staff serves as the subject matter experts on numerous boards and committees for many departments and agencies and representatives from those entities serve on DSAS committees as well.

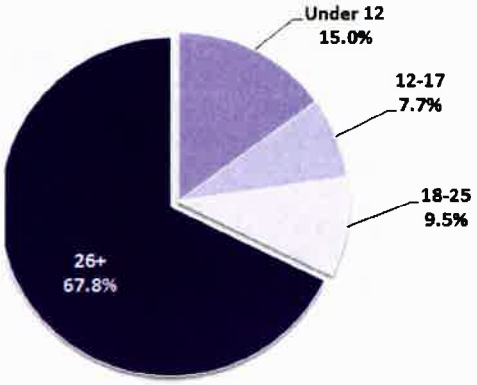
Grassroots organizations are the foot soldiers of the community. DSAS has brought a formal structure to existing organizations, assisted communities establish coalitions, and provided technical assistance on how to develop strategies, utilizing the Strategic Prevention Framework (SPF), to help prevent substance use and abuse. SPF ensures that the strategies are culturally appropriated and sustainable for the community. Local/county entities also assist with the delivery of prevention services. Many of the entities that serve as fiscal agents for our state-funded community coalitions are county entities that are donating space and other resources to ensure that their community coalition is effective and sustained into the future.

Establishing a relationship with the ***Judicial System and local law enforcement agencies*** has been essential to developing a structure for coordinating a system of care for non-violent offenders incarcerated or at risk of incarceration due substance use and abuse. There are thirty-one Judicial Districts in Tennessee. DSAS has joined forces with the General Sessions, Circuit, Criminal, Juvenile, Drug, Mental Health, Veteran and Family Courts, to coordinate behavioral health care for adult and juvenile offenders. Partnerships with law enforcement agencies has been essential for the community anti-drug coalitions to assist with Take Back events and disposal of drugs collected.

DSAS is building a cohesive prevention, treatment, and recovery network with ***Faith-Based Congregations/Organizations*** to support a common goal of strengthening individuals and families dealing with substance use disorders; and ultimately, restoring our communities. To become certified as a Faith-Based Congregation/Organization, you will be trained to provide Spiritual/Pastoral Support; view addiction as a treatable disease, not a moral issue; embrace and support people in recovery and walk with them on their journey; provide a visible outreach in the community; share recovery information; and host recovery support groups. Individuals can also be certified as ***Faith-Based Ambassadors***. They serve as a point of contact with DSAS, referral source for recovery support services, and the conduit for information sharing between the churches and organizations.

To understand how substance abuse services are delivered in Tennessee, it is important to understand the nature of the substance abuse problem and characteristics of the state's residents—including where populations are concentrated and how many people are approximately at risk. Tennessee is located in the South Eastern portion of the U.S. and is the 16th most populous state in the nation, with an estimated 6,600,299 residents (Census 2015 estimate). The population is predominantly White (80.2 percent) or African American (17.5 percent) with persons of other races comprising approximately two percent of the total resident population. Nearly one-quarter (22.7 percent) of the overall population are under the age of 18. This presents the possibility of substantial cohort effects if substance abuse intervention and treatment among youth can be implemented effectively. Cohorts whose rates of use are lowered tend to keep those lower rates throughout the aggregated lifetimes of its members. That is, a group of 18 year olds who have their use rates lowered should keep comparatively lower rates compared to other cohorts even when they are in middle age or become elderly. However, both the 12–17 and 18–25 age cohorts represent the smallest population size.[1]

Exhibit 1.1
2015 Tennessee Population by Age Category
U.S. Centers for Disease Control (CDC)

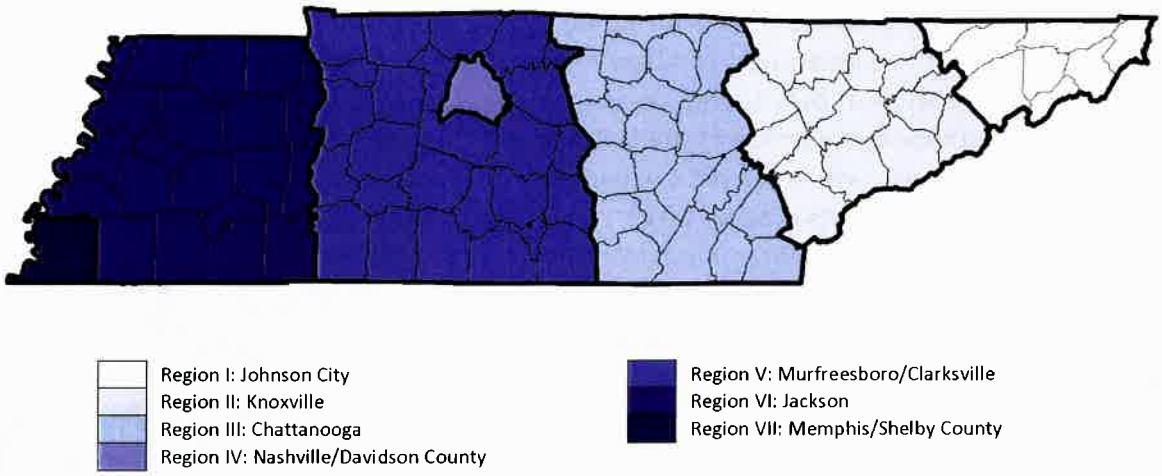


Populations in Tennessee by Age Range		
Age	Population	Percent
Under Age 12	987,137	15.0%
Age 12–17	510,474	7.7%
Age 18–25	626,568	9.5%
Age 26 or Older	4,476,120	67.8%
All Ages	6,600,299	

There are also seven geographic regions across Tennessee that have been established as state behavioral health planning or sub-State Planning areas. These regional designations allow for geographic analysis of survey data on prevalence rates and needs for treatment, as well as service utilization information provided by the State of Tennessee, Division of Substance Abuse Services. The seven Mental Health Planning Regions in Tennessee are displayed below.

[1] Statewide Assessment of Substance Use Disorders Prevention & Treatment Needs, *A Profile of Priority Needs for Prevention and Treatment, Current System Capacity and Services, and Implications for Service Priorities and Development*, State of Tennessee, 2013.

Tennessee Mental Health Planning Regions



Although DSAS' funding resources are projected to remain stable, TDMHSAS Commissioner regularly challenges us to develop and implement "low cost, high impact" programs. These programs have expanded, enhanced and strengthen DSAS' substance abuse services and state and community partnerships. Examples of "low cost, high impact" programs are:

- Community Coalitions
- DUI Schools
- Oxford Houses
- Faith-Based Recovery Network
- Lifeline Peer Program
- Alcohol and Drug Addiction Treatment Program
- Supervised Probation Offender Treatment Program
- Community Treatment Collaborative
- Recovery Courts
- Criminal Justice Liaisons Program

Prevention Services

DSAS' Prevention structure has three service components to address the prevention needs of individuals, communities, regions, and the State. This structure provides the essential framework and resources necessary to reach Tennessee's high need communities. Prevention service components include: provider agencies, prevention coalitions, and regional workgroups. Within this system, high need communities and populations are identified by a State Epidemiological and Outcomes Workgroup (SEOW) assessment. ***Provider agencies*** deliver culturally appropriate selected and indicated programs per an assessment through the Tennessee Prevention Network program. A network of county level ***coalitions*** *whose work is*

governed by the Strategic Prevention Framework (SPF) is the cornerstone of the prevention structure. They work to reduce underage alcohol use, underage tobacco use, and prescription drug use across the lifespan by working within their home communities to implement data based plans that endeavor to solve the problems in their community through environmental and community based strategies. Additionally, the Coalition for Healthy and Safe Campus Communities serves the Higher Education Institutions in Tennessee, a population known to be at great risk of alcohol and drug misuse. ***Regional Workgroups*** deliver universal indirect interventions, which leverage the efforts of individual coalitions and program providers by implementing environmental strategies in all areas of the state, including those areas without direct funding or a stand-alone program or coalition. All prevention providers are contractually required to take part in their respective Regional Prevention Council. The Regional Prevention Councils are responsible for leveraging and broadening the activities of community coalitions in their area. The Councils meet quarterly to discuss implementation of approved Regional Prevention Plans; and to identify and address specific prevention needs of the region.

The planning process allows different programs to meet the needs of the predominant high risk populations within their community. One unique program is the Deaf and Hard of Hearing program which serves the selective population of deaf and hard of hearing youth ages 6-20 and their families. Other prevention services programs include: School Based Mental Health and Substance Abuse Liaisons, Comprehensive Alcohol, Tobacco and other Drug Program, Synar and Partnerships for Success. All programs work to understand the unique diversity of the participants they are serving and have cultural humility in their relationships. Cultural humility incorporates a consistent commitment to learning and reflection, but also an understanding of power dynamics and one's own role in society. It is based on the idea of mutually beneficial relationships rather than one person educating or aiding another in attempt to minimize the power imbalances in client-professional relationships.

The purpose of implementing the SPF process is to ensure that the strategies and practices implemented as part of the SAPT Block Grant are effective, culturally appropriate, and sustainable. The SPF is a 5-step planning process that includes a comprehensive community assessment that guides the selection, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities. The assessment helps communities discern what their community looks like in terms of who makes up their community as well as the community consumption patterns or the way people drink, smoke and use illicit drugs. This information ensures that the strategies that are implemented are designed specifically to prevent others from using substances in a similar manner. The ultimate goal of SPF implementation is outcomes based prevention that focuses on population level change, emphasizing data-driven decision making. Cultural competence is a key portion of the SPF. It is part of each step of the process and is always a key consideration.

The State coordinates prevention activities through the Tennessee Prevention Advisory Council (TN-PAC). TN-PAC expands and strengthens prevention resources, reduces barriers, and increases communication throughout the prevention system. TN-PAC's members are comprised of state agencies; statewide organizations; regional prevention providers (including coalitions);

and the Director of Prevention Services. Its structure and membership intentionally reflects the diverse racial, ethnic, faith, socioeconomic and professional sectors of the State. The Evidence-Based Practices Workgroup has operationalized the definition of Evidence Based Practice (EBP) in Tennessee and serves as the expert panel to determine the viability of proposed interventions through a rigorous review and approval process. The SEOW profiles and prioritizes population needs, resources, service gaps and readiness capacity. It provides guidance to the comprehensive strategic planning process at state and community levels, and makes data-informed recommendations to the TN-PAC.

The Prevention Alliance of Tennessee (PAT) is a coalition of coalitions. This group represents all of the prevention coalitions within Tennessee, both those funded by the State as well as those coalitions who are not funded. The PAT allows coalitions in Tennessee to speak with a collective voice related to prevention issues in the State. The PAT has developed committees that develop white papers around topics important to the prevention system (i.e. marijuana legalization, prescription drug policies, etc.). Additionally, the PAT provides training and technical assistance to coalitions across the State

The Office of Prevention Services coordinates with several State Agencies to best deliver prevention services. The Department of Health is very interested in many of the substance misuse and abuse issues because they impact the physical health of many Tennesseans. The Department of Health is very interested in the prescription drug problem and has partnered with the TDMHSAS on legislation to increase the utility of the Controlled Substance Monitoring Database. Additionally, they have partnered with coalitions to delivery key prevention messages at physician training events across the state regarding how to safely prescribe opioids DSAS, in collaboration with the Department of Agriculture, addresses the issue of underage tobacco access through Synar. The Tennessee Department of Agriculture is responsible for coordinating and implementing the Synar survey. Tobacco compliance checks are completed statewide in establishments that sell tobacco products and are accessible to minors. Synar targets all youth under the age of 18.

DSAS has re-established it partnership with the National Guard, Counter Drug Task Force; Civil Operations Unity to provide well-trained and adaptable forces capable of developing anti-drug coalitions while implementing effective prevention practices.

Early Identification

DUI Schools in Tennessee provide educational intervention services based on ASAM Level 0.5, Early Intervention, to individuals that are mandated by the court to receive this service or want to reinstate their driver's license privileges. Offenders receive an assessment, education and, if indicated, appropriate treatment referral. DUI Schools use the *Prime for Life* curriculum as the statewide standardized curriculum. *Prime for Life* curriculum has been recognized by SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP). The core focus is on improving attitudes of the student and creating a positive outlook to decrease dependency by using the latest research on brain chemistry and addiction.

Through the Tennessee ***Suicide Prevention Network***, substance abuse professionals are trained on evidence-based suicide prevention strategies to eliminate and reduce the incidence of suicide across the life span, reduce the stigma of seeking help associated with suicide, and educate communities throughout Tennessee about suicide prevention and intervention. SABG treatment counselors are required to participate in the training. The goals of the training are:

a. To reduce the incidence of suicide and suicide attempts.

b. To educate the general public about suicide prevention and intervention.

c. To reduce the stigma associated with mental illness and suicide.

d. To be a resource for information about suicide.
e. To educate mental health and substance abuse counselors and program administrators about the high incidence of mental health and substance abuse disorders and suicide attempts and suicide deaths.

f. To promote the use of evidence-based practices and guidelines for suicide prevention education and training.

Treatment Services

DSAS' Treatment structure has four service components to address the needs of individuals, communities and the State. This structure provides the framework and resources necessary to plan, develop, administer, and evaluate a statewide system of services for the treatment of persons whose use of alcohol and/or other drugs has resulted in patterns of abuse or dependence. Treatment Services' components include: provider network, recovery courts, coalitions and TN RedLine. The ***provider network*** is the backbone of DSAS' treatment structure. They offer a full continuum of care based on the American Severity Index (ASI) screening tool and the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised (ASAM PPC-2R) to assess adults, pregnant women and women with dependent children; and the T-ASI and ASAM for adolescents. 98% of all treatment providers have been certified Co-Occurring Disorders Capable or Co-Occurring Enhanced Disorders. Utilizing state-funds, ***Recovery Courts*** provide treatment services on-site or refer individuals to DSAS-funded treatment agencies. ***Coalitions*** work to provide marketing and community linkages to promote resources. The ***TN RedLine*** operates a twenty-four hours per day/seven days per week (24/7) toll-free telephone line (TN-Redline) to answer questions and give referrals to individuals seeking information relative to substance use and abuse prevention, treatment, and recovery as well as co-occurring disorders and problem gambling. Other treatment services include: Medical Detoxification (state-funded); Medically Monitored Withdrawal Management; Tele-Treatment Program; HIV/AIDS Early Intervention Program; Problem Gambling Outreach, Education, Referral and Treatment Program; Opioid Treatment Program; and Medication Assisted Treatment.

Recovery Services

Recovery Services promotes client engagement in the recovery process and provides services needed for support of continued recovery. Its structure has three service components to address the needs of individuals, communities and the State – provider network, faith-based congregations/organizations and lifeline peer coordinators. Approximately ninety faith-based and non-faith based agencies provide recovery services through the ***provider network*** to keep individuals engaged in treatment or to provide continued recovery support. DSAS actively engage ***faith-based congregations/organizations*** as a means of increasing outreach, educational activities, access, and visibility to people seeking substance abuse services. ***Lifeline Peer Coordinators*** work to reduce stigma related to the disease of addiction, increase the number of recovery groups and meetings, and assist individuals in accessing treatment and/or recovery options in their community. Other recovery support programs are: Recovery Housing, Addictions Disorder Peer Recovery Support Centers and Peer Recovery Specialist Certification.

Treatment and recovery services are coordinated through the Tennessee Treatment and Recovery Advisory Council (TNTRAC). TNTRAC meets quarterly to provide guidance to the Division regarding programmatic (including the use of evidence-based practices), funding, and administrative decisions, as well as strategic planning. The Council is comprised of service providers and other stakeholders, as well as key Division staff. As needed, ad hoc committees are formed to address specific areas of concern/need. Each committee is co-chaired by members of TNTRAC with Division staff representation and 4 – 6 additional individuals representing provider agencies, advocates and consumers. There is an HIV, Women's Treatment and Recovery Committee and Adolescent Committee that meet at least annually or as often as needed. These committees are comprised of representatives from provider organizations as well as the State.

Criminal Justice

Criminal Justice is an integral part of our substance abuse system. Its' structure has two service components to address the needs of individuals, communities, regions, and the State. This structure provides the framework and resources necessary to plan, develop, administer, and evaluate a statewide system of services for persons incarcerated or at-risk of incarceration due to the use of alcohol and/or other drugs. The criminal justice components are diversion programs and recovery courts. DSAS has worked persistently to increase the ***diversion programs*** offered to offenders with substance use and mental health disorders. Through the Criminal Justice Behavioral Health Liaison Program, DSAS collaborates with jail administrators, public defenders, District Attorney's, judges, and sheriffs to screen and identify an individual's most immediate clinical or recovery support needs to divert him/her from re-entry into or out of jail or prison. Other diversion programs are: Alcohol and Drug Addiction Treatment (ADAT) DUI offenders, Supervised Probation Offender Treatment program, Community Treatment Collaborative for at-risk probation and parole technical violators. ***Recovery Courts*** incorporate intensive judicial supervision, treatment services, sanctions and incentives to address the needs of addicted non-violent offenders who meet the criteria of the drug court program and voluntarily want to participate in the program. Drug Courts, Mental Health and Veteran's

Courts, Family courts, Juvenile courts, and DUI courts are all part of the recovery court umbrella.

The Criminal Justice System serves a very diverse population. Effectively communicating with offenders is essential to providing successful behavioral health care coordination. DSAS requires all criminal justice providers to develop policies and procedures that address Limited English Proficiency for offenders with language barriers. Interpreters are available in all Recovery Courts.

The Recovery Court Advisory Committee works with TDMHSAS in reviewing program criteria, certification process and application, makes recommendations concerning implementation of programs and advises the Commissioner on the allocation of funds when funds are available. By law, the Recovery Court Advisory Committee is made up of the following representatives: two (2) judges who are currently presiding or have presided over a recovery court program for at least 2 years; two (2) recovery court coordinators who have functioned as a drug court coordinator in actively implemented recovery courts for at least 2 years; and at least two (2) additional members representing recovery court stakeholders (treatment/recovery support providers, court administrator, etc.). Staggered terms with initial appointments are established by the Commissioner. A member serves a four-year term and a member may be appointed to serve one additional consecutive term. Each member appointed represents a different region in the state (East, Middle and West).

Identify the unmet service needs and critical gaps within the current system.

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps." The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's NSDUH, TEDS, NSSATS, the Behavioral Health Barometer, and state data.
This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the SABG priority populations: Pregnant Women, Injecting Drug Users, Women with Dependent Children, Persons at Risk for Tuberculosis, Individuals in Need of Primary Substance Abuse Prevention, and, for HIV-designated states, Persons at Risk for HIV.
In addition, this narrative must include a description of the composition of the State Epidemiological Outcomes Workgroup and its contribution to the state planning process.

The *Tennessee Substance Use Disorders Prevention and Treatment Needs Assessment* process is used to facilitate and inform decisions about state priorities for policy making and resource allocation to ensure accountability and promote the achievement of intended results with respect to behavioral health problems in Tennessee. The decision process incorporates the use of criteria and data to prioritize issues and appropriate strategies for addressing behavioral health problems. To establish need, the assessment follows a more comprehensive evidence-based process that includes: a) using research-generated knowledge, i.e.; substance use prevalence, consumption patterns, and trends in local or national populations, about the epidemiology and consequences of substance use disorders to target those circumstances and behaviors that are particularly associated with consequences and social cost; b) state and county level data sources are used to document incidence, prevalence and trends in consumption patterns and use consequences in Tennessee. Data is drawn from multiple sources, such as state wide school surveys (e.g., CDC's Youth Risk Behavior Survey), crime and health indicators, and reports; and c) identifying those accessible populations that are at high risk for substance use disorders and/or have constrained access to services. A variety of data sources and existing research was used to identify and rank priority needs for substance use disorders in Tennessee. These data sources consist of the U.S. Census; Healthy People, 2010; National Center on Addiction and Substance Abuse (CASA); National Institute of Drug Abuse (NIDA); Youth Risk Behavior Surveillance System; National Survey on Drug Use and Health; Treatment Episode Data Set (TEDS); etc. Interviews and focus groups were conducted with treatment and recovery support providers and other community stakeholders to determine local gaps and needs; program development issues; and concerns and technical assistance needs. DSAS Leadership utilized the needs assessment, data generated from the Tennessee Web-based Information Technology System (TN WITS), SAMHSA's Strategic Initiatives and reports from TDMHSAS' Division of Research, Planning and Forensics. The state priorities were presented to the Statewide Planning and Policy Council for review and comment.

Development of the needs assessment was closely guided by the State Epidemiological and Outcomes Workgroup (SEOW). Tennessee's SEOW is composed of representatives of the Tennessee Department of Mental Health and Substance Abuse Services, the Tennessee Bureau of Investigation, the Tennessee Department of Health, the Tennessee Department of Safety and Homeland Security, the Tennessee Department of Correction, the Tennessee Department of Military, the Tennessee Division of Health Care Finance and Administration, the Tennessee Department of Children's Services, the Tennessee Department of Education, East Tennessee State University, Oasis Center, Inc., and Allies for Substance Abuse Prevention of Anderson County. The SEOW profiled and prioritized population need, resources, service gaps and readiness capacity. They provided guidance to the comprehensive strategic planning process at the state and community levels; and made data-informed recommendations. A list of recommended priorities was provided to the Tennessee Prevention Advisory Council for consideration. The priorities are listed below in Exhibit 2.1 in the Column entitled "Prevention Service Needs" by Age Cohort.

Substance use disorder services are important because those disorders produce serious consequences for individuals, families and society. Need is not determined simply by substance use or abuse, but by those behavior patterns (i.e., disorders) that are highly associated with negative consequences, and by those vulnerable populations that are most likely to exhibit these patterns of behavior and remain underserved or unserved. Data concerning the incidence and prevalence of use in a population becomes much more useful if there is a focus on those indicators that are most highly associated with the negative consequences that are the cause for concern. Data on problems is also more useful if it provides guidance on who is most likely to experience these problem behaviors, and how they can be identified for outreach and improved service access. To support a service system that helps apportion services according to need, data and findings are organized according to seven age cohorts (see Exhibit 2.1). Utilizing this approach associates the indicator data with consequences, prevalence in Tennessee and the presence of vulnerable populations at high risk for developing substance use disorders in the cohort.

Exhibit 2.1. Lifelong Indicators and Targets of Substance Use Disorder Needs for Tennessee: Behaviors and Vulnerable Populations

Age Cohort	Priority Cohort Problem Indicators	Relevant Target Populations	Prevention Service Needs	Treatment Service Needs
Neo-natal to 5 years		• Female substance abusers • Families experiencing Domestic Violence • Families experiencing substance related Health Problems • Families in low service rural areas	• Family programs, • Community awareness and system improvements	• Female treatment access and orientation • Anger management • Domestic violence interventions
6 to 10 years	• Early initiation	• Female substance abusers • Families experiencing Domestic Violence • Families experiencing substance related Health Problems • Families in low service rural areas, • Youth with low school performance/ truancy	• Family programs • Community awareness and system improvements • Age appropriate selective prevention (e.g., mentoring)	• Female treatment access and orientation • Anger management • ,Domestic violence interventions • School outreach programs

		• Homeless families		
11 to 13 years	• Early initiation • Inhalant use • Mental health disorders	• Youth with low school performance/ truancy • Youth in Foster Care System	• Community programs for youth development • Age appropriate selective and indicated prevention • Family programs	• Counseling services • Mental health counseling • Family counseling
14 to 17	• Binge drinking • Prescription drug use • Mental health disorders • High risk illicit drug use	• Youth in Juvenile Justice System • High School Dropouts	• Selective and indicated programs • Brief interventions • Community awareness and systems improvement • Age appropriate indicated prevention • Age appropriate environmental policies	• Adolescent treatment • Recovery support services • Recovery high schools
18 to 25 years	• Binge drinking • Methamphetamine use • Prescription drug use • DUI • Substance abuse and dependence	• Transition-aged Youth • Victims of Trauma • Veterans • Smokers	• Environmental policies • College focused programs	• Young adult oriented treatment and outreach • Comprehensive treatment and recovery support services • Collegiate recovery communities
26 to 55 years	• Substance Abuse and Dependence • DUI • Prescription drug use	• Military families • Victims of Trauma • Female substance abusers • Minority populations • Veterans • Smokers • Rural populations • Persons experiencing physical health conditions	• Environmental policies	• Culturally responsive treatment, Outreach, Co-occurring disorders programs
Over 55 years	• Substance abuse and dependence • Prescription drug use	• Military families • Victims of Traumas • Female substance abusers • Minority populations • Veterans • Smokers • Persons experiencing physical health conditions	• Environmental policies	• Culturally responsive treatment, Outreach, Co-occurring disorders programs

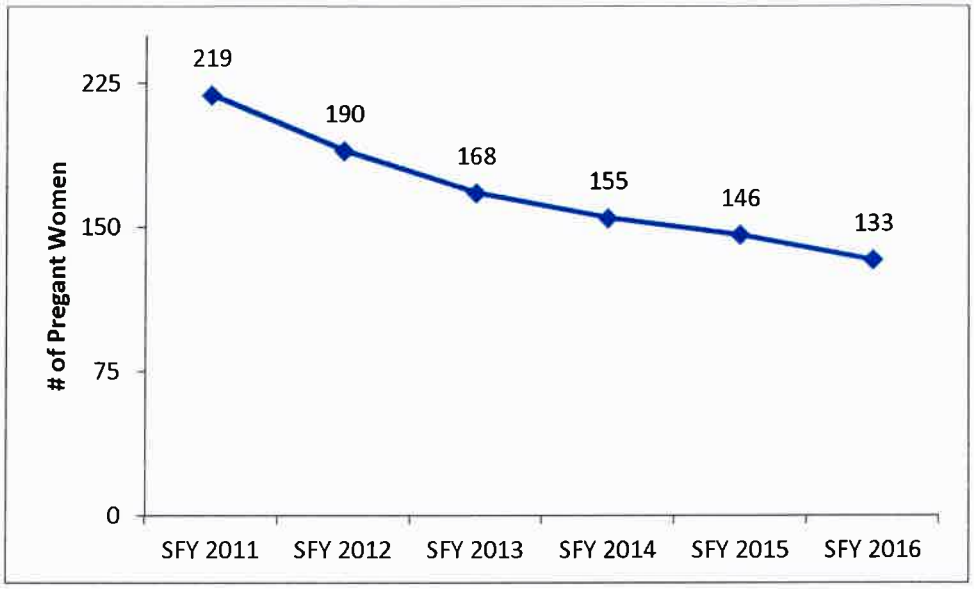
The identification of vulnerable populations with high risk for specific disorders and/or challenges in accessing services provides a practical and credible approach to effectively targeting outreach for treatment and prevention services.
DSAS leadership analyzed data from the needs assessment, TN WITS and the SEOW in conjunction with SAMHSA's Strategic Initiatives to prioritize which vulnerable populations, including the SABG priority populations, will be addressed in SFY 2018 and SFY 2019.

Female Substance Abuse – Pregnant Women and Women with Dependent Children (PWWDC)
Through an agreement with fourteen (14) non-profit providers, Tennessee ensures the following services for PWWDC:

- Preference in admission to treatment
- Referral for primary medical care
- Childcare and prenatal care; including immunization
- Gender specific treatment and other therapeutic interventions for women
- Referral for therapeutic interventions for children in custody of women in treatment
- Case management
- Transportation

Providers are required to publicize the availability of services for PWWDC. If the provider does not have capacity, they notify the State and the State assist with locating a treatment facility and/or ensure that interim services are provided until a facility is located.
Although comprehensive services are offered for PWWDC, there was a noticeable decline in the number of pregnant women seeking treatment services after SFY 2011. In SFY 2011, two hundred-nineteen (219) pregnant women sought treatment compared to one hundred forty-six (146) in SFY 2015, which is a 33% decrease. Retaining pregnant women in treatment has also been a challenge. In SFY 2015 (July 1, 2014 – June 30, 2015), 45% of the pregnant women who sought treatment at our contracted agencies were discharged due the agency losing contact with the woman or the woman left the agency against medical advice.

 # Pregnant Women Served by State Fiscal Year
2011 – 2016



TDMHSAS - DASAS FY 11 - 16 Discharge Status by Fiscal Year for Pregnant Women							
	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	Grand Total
Unsuccessful	**68.15%**	**51.83%**	**50.72%**	**56.52%**	**57.00%**	**44.21%**	**55.40%**
Administratively Discontinued	28.66%	16.46%	16.67%	18.26%	22.00%	7.37%	18.86%
Lost contact/Left against medical advice	36.31%	28.66%	31.16%	33.04%	29.00%	34.74%	32.12%
Treatment not complete referred to other SA treatment progra	3.18%	6.71%	2.90%	5.22%	6.00%	2.11%	4.42%
Neutral	**5.73%**	**7.93%**	**5.07%**	**6.09%**	**4.00%**	**9.47%**	**6.37%**
Client Moved	0.00%	1.22%	0.72%	0.00%	2.00%	2.11%	0.91%
Client's needs exceeded provider's offerings	5.10%	3.05%	1.45%	0.87%	2.00%	1.05%	2.47%
Incarcerated	0.64%	3.66%	2.90%	5.22%	0.00%	6.32%	2.99%
Successful	**26.11%**	**40.24%**	**44.20%**	**37.39%**	**39.00%**	**46.32%**	**38.23%**
No further care indicated	0.64%	1.83%	3.62%	2.61%	5.00%	3.16%	2.60%
Treatment completed additional services advised	3.18%	5.49%	4.35%	5.22%	1.00%	3.16%	3.90%
Treatment completed no referral	5.73%	11.59%	11.59%	8.70%	9.00%	10.53%	9.49%
Treatment completed referral made	16.56%	21.34%	24.64%	20.87%	24.00%	29.47%	22.24%

As a result of the above data, Tennessee requested technical assistance from SAMHSA to assist the state with *"Improving Engagement and Retention of Pregnant and Parenting Women in Treatment Services"*.

Through the technical assistance, one of the gaps that the providers indicated was the need for more comprehensive treatment services for the whole family. The consultants provided training on *Family-Centered Treatment: Defining What "Good Care" Looks Like for Women and Their Families.* Through the training, we learned that women place high values on their relationships and families, treatment should focus on promoting and supporting healthy attachment and relationships between parents and children and on women's relationships with

others. Family-centered treatment helps not only the woman dealing with adverse outcomes of drug use — it also helps her family and their needs.

Research on women's substance use, dependence, and treatment shows that relationships, especially with family and children, has been shown to play an important role in women's substance use, treatment and relapse. Therapeutic services and improved parenting increase the prognosis and outcomes for mothers and their children. When whole families are treated, outcomes for each individual member improve while simultaneously the communication, coordination, and ability of adult members to support one another and the children increase. It has been shown that Family-Centered Treatment results in improved treatment retention/outcomes for individual women as well as improved outcomes for children and other family members. Relational outcomes include improvements in parenting, family functioning, and the number of families reunified or remaining intact and improved communication. As families transform, parenting improves, family norms shift, and economic and social well-being can increase.[1]

Family-Centered Treatment includes five levels of family-based services with Level 1 focusing on the woman but addressing family relationships as an integral part of the treatment process up to Level 5 which provides services for women, their children, and the children's fathers or other family members. Some of the characteristics of Family-centered treatment are:

- Comprehensive
- Women define their families
- Treatment is based on the unique needs and resources of individual families
- Families are dynamic and thus treatment must be dynamic
- Conflict is inevitable, but resolvable
- Meeting complex family needs requires coordination across the systems
- Substance use disorders are chronic, but treatable
- Services must be gender responsive and specific and culturally competent
- Family-centered treatment requires an array of staff professionals as well as an environment of mutual respect and shared training
- Safety comes first
- Treatment must support creation of healthy family systems

Therefore, DSAS has decided to incorporate family-centered treatment into its women's services program. In SFY 2018, DSAS will identify the level of family-centered services currently offered by its women's providers and community assets and resources that are available to them. In SFY 2019, DSAS will work with women providers to add family-centered services; and assist them with forging partnerships with community resources, including faith-based organizations, to increase retention and engagement in treatment.

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[1] Werner, D., Young, N.K., Dennis, K, & Amatetti, S.. *Family-Centered Treatment for Women with Substance Use Disorders – History, Key Elements and Challenges.* Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2007.

Individuals with a Diagnosis of Opioid or Heroin Use Disorders – Injecting Drug Users

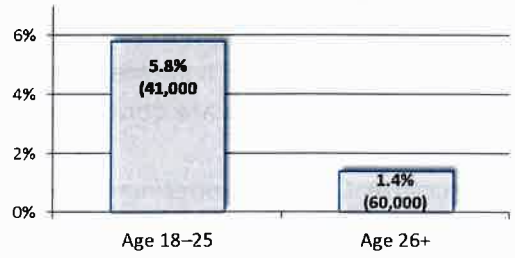
The opioid use disorder (OUD) epidemic is a national problem that requires partnerships among federal, state, and local organizations to address prevention, treatment and recovery services. According to reports from the Centers for Disease Control (CDC), more individuals died from drug overdoses in the United States in 2014 than during any previous year.[2] The State of Tennessee mirrors these observations. The abuse of prescription opioids and heroin is at epidemic levels with disastrous and severe consequences to Tennesseans of every age. In 2010, Tennesseans were three times more likely to identify prescription opioids as their primary substance of abuse than the national average.[3] Heroin treatment rates have grown more than four times in the past five years in metropolitan counties of the state from a low of 6.9 per 10,000 of poverty population to 28.8.

TN data from the National Survey on Drug Use and Health (NSDUH 2014)[4] reveals that in the past year 8.3% of 18-25 year-olds and 3.1% 26+ year-olds used pain relievers for non-medical purposes. In 2015, the rate of admissions for state funded opioid treatment was 18.8 per 10,000. When analyzed regionally, two of the affected regions in eastern Tennessee have rates of 26.1 per 10,000. These use rates and the consequences associated with them are devastating to individuals, families, communities, regions and to the State of Tennessee and must be addressed.

Data collected as of March 31, 2014 by the National Survey of Substance Abuse Treatment Services (N-SSATS) indicates that Tennesseans are unlikely to be in treatment compared to other states. Tennessee ranks in the lowest quartile of states in terms of residents in treatment with less than 390 admissions per 100,000 population. Chart 1 compares the percentages of Tennesseans who needed treatment for illicit drug use but did not receive it across age categories, based on 2013–14 annual averages. Tennessee performs on average in providing treatment services for illicit drug use when compared to other states.
Tennessee ranks in the in the middle quintile of states of those in past year need for illicit drug use treatment but not receiving it.

Chart 1.

Tennesseans Needing but Not Receiving Treatment for Illicit Drug Use by Age Group



Source: 2013 – 14 NSDUH

Chart 1 also presents the number of Tennesseans impacted. Adolescent Tennesseans do better with regard to access to treatment than older Tennesseans. That this does not improve Tennessee's rank in overall access is, perhaps, indicative that the state does especially poorly for older adult residents.

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[2] Rud, R., Seth, P., David, F. & Scholl, L. Increases in drug and opioid-involved overdose deaths-United States, 2010-2015. Morbidity and Mortality Weekly Report, Early Release, December 16, 2016, Centers for Disease Control and Prevention.

[3] Substance Abuse and Mental Health Service Administration. (2012) Treatment Episode data set – Admissions (TEDS-A). U.S Health and Human Services, Washington, D.C.

[4] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013 and 2014.

Tennessee ranks in the second highest quintile for residents 18–25 and those Tennesseans older than 26.

The OUD issue in Tennessee is statewide but depending upon the type of opioid the use pattern can differ greatly. Data for heroin related indicators shows greater rates in the urban areas and moving to suburban areas, while prescription opioid related indicators show greater rates in rural areas of the state.

All block grant treatment providers are required to treat individuals who inject drugs. They are contractually required to do the following:

- Notify the State upon reaching 90% capacity to admit individuals in its programs
- Admit an individual who request treatment no later than 14 days after request or within 120 days after request has been made if the treatment facility does not have capacity
- If there isn't capacity to admit the individual, notify the State to assist with placement
- Provide interim services within 48 hours and continue to encourage injecting drug users to seek treatment

As a response to the increase in opioid use disorders and overdose deaths, in SFY 2017, DSAS added medication assisted treatment (MAT) as a service for block grant treatment providers. Also, the Tennessee General Assembly appropriated state funds to DSAS to pilot naltrexone in the recovery courts. In SFYs 2018 and 2019, DSAS intends to continue offering MAT as a service through the SAPT Block Grant. Also, for SFY 2018, the Tennessee General Assembly re-appropriated state funds for the recovery courts.

Individuals at Risk for Tuberculosis

Through consultation with the Tennessee Department of Health, Tuberculosis Elimination Program, DSAS developed policies and procedures to identify and prevent active tuberculosis (TB) disease and TB infection (TBI) among employees, volunteers, and service recipients in alcohol and drug (A&D) treatment programs and prevention programs that offer direct services. All treatment providers are contractually required to meet the requirements of the

Tuberculosis Control Guidelines for Alcohol and Drug Abuse Treatment Programs.

Requirements for TB screening and testing include:

- Testing and medical evaluation to determine the presence or absence of active TB disease or TBI in employees and volunteers of alcohol and drug treatment programs and recipients of alcohol and drug treatment services must conform to current guidelines of the Tuberculosis Elimination Program of the Tennessee Department of Health.
- A&D treatment facilities must provide baseline screening of all new employees and new volunteers for symptoms of active TB disease and appropriate testing for TBI prior to employment or provision of volunteer services.
- A&D treatment facilities must ensure that all employees and volunteers who provide direct care services are screened annually for symptoms of active TB disease and appropriately tested for TBI.

- A&D treatment facilities must counsel all employees and volunteers annually regarding the symptoms and signs of active TB disease.
- Any A&D treatment program employee or volunteer with symptoms suggestive of active TB disease must be referred immediately for appropriate medical evaluation and cleared by a licensed medical provider prior to return to work in the facility or provision of direct care services.
- Any A&D treatment program employee or volunteer reported by a health care provider to the health department as having suspected or confirmed active TB disease must be excluded from the facility and from provision of direct care services until the employee or volunteer is determined to be non-infectious by the local health department.
- All A&D treatment facilities must screen all prospective service recipients for symptoms suggestive of active TB disease prior to each admission for A&D treatment services.
- Prospective service recipients presenting with symptoms suggestive of active TB disease must be referred immediately for appropriate medical evaluation and cleared by a licensed medical provider prior to admission for A&D treatment services.
- Any service recipient reported by a health care provider to the health department as having suspected or confirmed active TB disease must be excluded from services until the service recipient is determined to be non-infectious by the local health department.
- Prospective recipients of all A&D treatment services who present without symptoms of active TB, and have no documentation of a previous positive TB test and have no documentation of testing for TBI within the past six (6) months must be appropriately tested for TBI within five (5) business days of initiation of A&D treatment services. The exceptions for testing are Outpatient ASAM Levels 1, 2.1 and 2.5; however, all service recipients must be screened for symptoms of active TB disease.
- A&D treatment facilities must counsel all service recipients about the symptoms and signs of active TB disease during each admission for A&D treatment services.
- All A&D treatment facilities must provide case management activities to ensure that employees, volunteers, and service recipients diagnosed with TBI receive appropriate medical evaluation, counseling about the risk of TBI progressing to active TB disease, and TBI treatment if such treatment is recommended to and accepted by the employee, volunteer, or service recipient.
- Testing for TBI may be conducted by qualified medical personnel at an A&D treatment facility or by referral to a licensed medical provider.
- All TB screening and testing records of employees, volunteers, and service recipients are considered personal medical information protected by HIPAA and must be archived accordingly.

DSAS has an agreement with all public health departments to provide testing for DSAS funded treatment agencies that do not have the capacity to perform the TB test. Individuals present DSAS' screening tool to the health department and gives consent to communicate the test results to the treatment agency.

To increase provider's knowledge about the risk factors and symptoms of TB, DSAS provides an on-line training course and examination. When the individual passes the exam, a certificate is provided acknowledging their success. To increase individual's knowledge, DSAS added questions to the HIV pre- and post-test to gauge the effectiveness of the training offered at the treatment facilities. In SFY 2018 and 2019, DSAS intends to continue offering the on-line training course and training at the substance abuse treatment facilities.

Individuals at Risk for HIV

As an HIV Designated State, Tennessee provide services to individuals at risk for contracting and/or transmitting HIV/AIDS including those in alcohol and drug abuse treatment programs with substance abuse and addiction disorders, their families and alcohol and drug treatment professionals. Services include:

(1) Short-term counseling services to individuals and/or families;
(2) Educational activities to groups;
(3) Oral Rapid HIV testing to individuals, including pre- and post-test counseling; and Hepatitis testing to individuals.
(4) Ongoing training activities to increase the knowledge of HIV and AIDS for professional staff at each alcohol and drug abuse treatment service provider and recovery support provider in the Grantee's region; and
(5) Training of service recipients from alcohol and drug abuse treatment service and recovery support service providers in the Grantee's region using information gathered in the course entitled "The Fundamentals of HIV Prevention Counseling", or the most current successive training course endorsed by the United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC).

There are nine HIV providers located in the areas of the state with the greatest need. The goals of the HIV/EIS program are:

- To increase the number of individuals identified who are at risk for contracting and/or transmitting HIV/AIDS and Hepatitis
- To prevent individuals from becoming infected with and/or transmitting HIV/AIDS and Hepatitis.
- To increase the knowledge of HIV/AIDS and Hepatitis to those persons who are at risk and their families.
- To make early intervention services for HIV/AIDS and Hepatitis available to individuals in alcohol and drug abuse treatment and recovery support programs, and identify and refer individuals needing social and medical services for HIV/AIDS, and Hepatitis to the appropriate services.
- To increase the knowledge and skills of alcohol and drug treatment professionals regarding HIV/AIDS and Hepatitis.
- To continually assess the needs of alcohol and drug abuse treatment and recovery support programs and coordinate liaison and service delivery for potential service recipients.

In SFYs 2018 and 2019, DSAS plans to continue evaluating the HIV/EIS services utilizing the pre- and post-test to maintain the effectiveness of the program.

Prioritize State Planning Activities

Using the information in Step 2 (Identify the unmet service needs and critical gaps within the current system), states should identify specific priorities that will be included in the MHBG and SABG. The priorities must include the core federal goals and aims of the MHBG and SABG programs: target populations (those that are required in legislation and regulation for each block grant) and other priority populations described in this document. States should list the priorities for the plan in Plan Table 1 and indicate the priority type (i.e., substance use disorder prevention (SAP), substance use disorder treatment (SAT), or mental health services (MHS).
Step 4: Develop goals, objectives, performance indicators, and strategies
For each of the priorities identified in Step 3, states should identify the relevant goals, measureable objectives, and at least one-performance indicator for each objective for the next two years.

For each objective, the state should describe the specific strategy that will be used to achieve the objective. These strategies may include developing and implementing various service-specific changes to address the needs of specific populations, substance abuse prevention activities, and system improvements that will address the objective.

Priority 1

Priority Area: Prevention

Priority Type: Substance Abuse Prevention (SAP)

Population: Primary Prevention (PP)

Goal: **Increased awareness of the consequences of underage drinking**

Objective: Prevent and reduce the consequences of underage drinking

Strategy: Continue to provide funding for underage drinking/prevention coalitions to implement activities and strategies activities statewide. Continue to provide funding for contracted substance use prevention provides (selected and indicated populations) to provide activities and strategies for underage drinking such as Friendly PEERsuassion and Be Sharp's Keepin' it REAL

Indicator: Number of youth and community members attending prevention of underage drinking activities by prevention coalitions

Baseline Measurement: NA

1st yr target/

outcome:	Increase the number of youth their families and community members who receive underage drinking education and prevention activities by 2%.
2nd yr target/ outcome:	Increase the number of youth their families and community members who receive underage drinking education and prevention activities by 3%.
Data Source:	TN WITS data entered by coalitions and Tennessee Office of Prevention (TOPS) Youth Prevention Survey
Description of Data:	TN-WITS and Quarterly TOPS reports indicate the types and number of youth, family, and community members reached.
Data issues/ caveats that affect outcome:	No issues are currently foreseen that will affect the outcome measure

Priority 2	
Priority Area:	Intravenous Drug Users
Priority Type:	Substance Abuse Treatment (SAT)
Population:	IVDUs
Goal:	All contracted providers will provide treatment services to intravenous drug users
Objective:	To ensure intravenous drug users are receiving treatment services
Strategy:	Contracted agencies will provide treatment services to intravenous drug users and will be monitored for compliance through DSAS' contract monitoring process.
Indicator:	Percentage of individuals who disclosed that they were an intravenous drug user.
Baseline Measurement:	30%
1st yr target/	

Outcome:	32%
2nd yr target/ Outcome:	34%
Data Source:	Tennessee Web-based Information Technology System (TN-WITS)
Description Of Data:	Clients who, during the intake process, responded "yes" to Injection Drug User.
Data issues/ caveats that affect outcome:	Potential budget reductions and route of administration

Priority 3	
Priority Area:	Pregnant Women and Women with Dependent Children (PWWDC)
Priority Type:	Substance Abuse Treatment (SAT)
Population:	PWWDC
Goal:	Improve engagement and retention outcomes for Pregnant Women and Women with Dependent Children
Objective:	To assess the need of PWWDC for family-centered services
Strategy:	Identify the level of services currently offered, community assets and resources available
Indicator:	Number of survey responses that indicate services currently offered, community assets and resources
Baseline Measurement:	None
1st yr target/ Outcome:	Survey women treatment providers to determine the level of services currently offered, community assets and resources available
2nd yr target/ Outcome:	Add to contract the requirement to assess the need and referral for family centered services

Data Source: Survey and contractual agreements

Description of Data: Survey Monkey and grant contracts

Data issues/ caveats that affect outcome: No issues are currently foreseen that will affect the outcome measure

Priority 4

Priority Area: PWWDC

Priority Type: SAT

Population: PWWDC

Goal: Increase relationships between women's treatment facilities and community partners

Objective: To forge partnerships with faith-based organizations and women's treatment programs

Strategy: Identify faith-based organizations to becomes mentors for women's treatment programs

Indicator: Number of partnerships developed between faith-based organizations and women's treatment programs

Baseline Measurement: None

1st yr target/ Outcome: Survey faith-based organizations to determine level of interest, types of activities or programs, etc.

2nd yr target/ Outcome: Develop partnerships between faith-based organizations and women's treatment programs

Data Source: Survey and faith-based provider list

Description Of Data: Survey Monkey and faith-based provider list

Data issues/ caveats that affect outcome: No issues are currently foreseen that will affect the outcome measure

Priority 5

Priority Area: HIV

Priority Type: SAT

Population: EIS HIV

Goal: Evaluate the DSAS funded HIV/EIS services in Tennessee to maintain the effectiveness of the program

Objective: To address needs of individuals with or at risk of contracting HIV

Strategy: Use a standardized pre- and post- test to determine if HIV/EIS services are effective.

Indicator: Post-test scores of consumers who are enrolled in treatment and completed the pre- and post-test.

Baseline Measurement: 88%

1st yr target/ Outcome: 88%

2nd yr target/ Outcome: 88%

Data Source: Pre- and Post HIV/EIS/TB/HCV test

Description Of Data: The Pre- and Post-HIV/EIS/TB/HCV test is a client's personal risk assessment administered before and after HIV testing. It is used as a teaching tool, correct misinformation and identifies personal risks and coping strategies

Data issues/ caveats that Affect outcome: No issues are currently foreseen that will affect the outcome measure

Priority 6

Priority Area: Tuberculosis (TB)

Priority Type: SAT

Population: TB

Goal: Increase block grant treatment provider's knowledge about the risk factors, symptoms and testing methods for Tuberculosis (TB).

Objective: To address needs of individuals with or at risk of contracting TB

Strategy: Use a standardized pre- and post- test to determine if TB training is effective.

Indicator: Post- test scores of consumers who are enrolled in treatment and completed the pre- and post-test

Baseline Measurement: **71%**

1st yr target/ Outcome: **75%**

2nd yr target/ Outcome: **75%**

Data Source: Pre- and Post TB test

Description Of Data: The Pre- and Post-HIV/EIS/TB/HCV test is a client's personal risk assessment administered before and after HIV testing. It is used as a teaching tool, correct misinformation and identifies personal risks and coping strategies.

Data issues/ caveats that affect outcome: No issues are currently foreseen that will affect the outcome measure

Priority 7

Priority Area: Criminal Justice

Priority Type: SAT

Population: Other – Criminal Justice

Goal: Provide diversion opportunities for individuals in the criminal justice system with a substance use or co-occurring disorder.

Objective: Provide substance abuse and co-occurring treatment services that are culturally responsive to individuals involved in or at risk of involvement in the criminal justice system

Strategy: Make available programs that serve individuals who have been convicted of a non–violent crime and have a substance use or co-occurring disorder.

Indicator: Number of individuals receiving diversion services

Baseline Measurement: 8,900 offenders

1st yr target/ Outcome: 9,500 offenders

2nd yr target/ Outcome: 9,600 offenders

Data Source: Tennessee Web-based Information Technology System (TN-WITS)

Description Of Data: Offenders who have a group enrollment in the Alcohol and Drug Addiction Treatment Program, Supervised Probation Offender Treatment Program, Community Treatment Collaborative, Recovery Courts, and Criminal Justice Liaison Program

Data issues/ caveats that Affect outcome: Potential budget reductions

Priority 8

Priority Area: Criminal Justice

Priority Type: SAT

Population: Other – Criminal Justice

Goal: Ensure quality services are delivered through the recovery court system.

Objective: To provide substance abuse and co-occurring treatment services that are culturally responsive to individuals involved in or at risk of involvement in the criminal justice system

Strategy: Certify new and recertify existing recovery courts utilizing the National Drug Court Ten Key Components

Indicator: Number of drug courts certified and recertified

Baseline Measurement: 11 certifications

1st yr target/ Outcome: 16 certifications

2nd yr target/ Outcome: 18 certifications

Data Source: Certification documents and site visit

Description Of Data: A team of peers review the application, policies and procedures and participant handbook. Staff observes team staffing of court session.

Data issues/ caveats that affect outcome: Funding request may impact new certifications

Priority 9

Priority Area: Workforce Development

Priority

Type:	SAP
Population:	Other – Prevention, Treatment and Recovery Support Workforce
Goal:	**Maintain** the knowledge of evidence-based programs and strategies for the prevention, treatment, and recovery support workforce.
Objective:	Enhance professional growth of the substance abuse prevention, treatment and recovery support workforce.
Strategy:	Provide on-line and regional face-to-face educational and training opportunities for prevention, treatment and recovery support professionals.
Indicator:	Increase the number of persons receiving training.
Baseline Measurement:	1,600 persons
1st yr target/ Outcome:	1,600 persons
2nd yr target/ Outcome:	1,600 persons
Data Source:	Attendance sheets of training classes, on-line training records
Description Of Data:	Attendance sheets are maintained during training courses and are used to determine the number of individuals that attended training. Additionally, online training is tracked through a report generated from the on-line systems.
Data issues/ caveats that affect outcome:	Potential budget reductions

Priority 10	
Priority Area:	Recovery Support
Priority Type:	SAT
Population:	Other – Persons in need of recovery support services

Goal:	Supplement treatment service with recovery support services
Objective:	Provide culturally responsive opportunities for individuals to access recovery support services
Strategy:	Provide an array of recovery support services for adult and adolescent consumers to supplement their treatment and to increase their chances of long term sobriety. These services may include case management, transportation, transitional housing, recovery support groups, spiritual/pastoral support, relapse prevention, etc.
Indicator:	Number of consumers currently enrolled in recovery services.
Baseline Measurement:	5,772 consumers
1st yr target/ Outcome:	6,272 consumers
2nd yr target/ Outcome:	**6,772 consumers**
Data Source:	Tennessee Web-based Information Technology System (TN-WITS)
Description Of Data:	Consumers who receive recovery support services
Data issues/ caveats that Affect outcome:	Potential budget reductions.

Priority 11	
Priority Area:	Recovery Support
Priority Type:	SAT
Population:	Other – Persons in need of recovery support services
Goal:	Expand access to recovery support services through the faith community

Objective:	To provide culturally responsive opportunities for individuals to access recovery support services
Strategy:	Certify recovery congregation/community organizations on the Tennessee Faith-based Community Initiatives
Indicator:	Number of faith-based congregations/organizations certified
Baseline:	220 congregations/organizations
1st yr target/ Outcome:	Additional 30 congregations/organizations
2nd yr target/ Outcome:	Additional 30 congregations/organizations
Data Source:	Faith-based Network Certification documents
Description Of Data:	Best Practices for faith-based recovery support
Data issues/ caveats that Affect outcome:	No issues are currently foreseen that will affect the outcome measure

Priority 12	
Priority Area:	Trauma
Priority Type:	SAT
Population:	Other: Individuals who have experienced trauma
Goal:	Treatment agencies will provide assurance that individuals who have experienced trauma are receiving trauma informed care services
Objective:	Address the needs of individuals who have experienced trauma
Strategy:	Individuals who have disclosed experience with trauma
Indicator:	Number of individuals who have been screened for trauma.

Baseline Measurement: 8,620
1st yr target/ Outcome: 9,051
2nd yr target/ Outcome: 9,504

Data Source: Tennessee Web-based Information Technology System (TN-WITS)

Description Of Data: Individuals who, during the intake process, responded "yes" to Violence or Trauma

Data issues/ caveats that Affect outcome: Potential budget reductions.

Priority 13:
Priority Area: Recovery Housing

Priority Type: SAT

Population: Other: Homeless

Goal: Expand self-supporting and drug free homes through Oxford House International for individuals in recovery

Objective: Provide recovery housing for individuals in recovery from drug and alcohol addiction

Strategy: Establish new recovery houses statewide.

Indicator: Number of new recovery houses

Baseline Measurement: 56 houses

1st yr target/ Outcome: Add 9 new recovery houses

2nd yr target/ Outcome: Add 10 new recovery houses

Data Source: Monthly reports

Description Of Data: Monthly reports give details on established and newly established homes; i.e., location, number of bedrooms, numbers of individuals residing in home, etc.

Data issues/ caveats that Affect outcome: Potential budget reductions.

The Health Care System, Parity and Integration

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders. The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations. Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment. Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care

settings or arrangements to provide primary and specialty care services in community - based mental and substance use disorders settings.

December 2016, TennCare, State Medicaid Authority, launched an initiative called "Tennessee Health Link" (THL). The primary objective of THL is to coordinate health care services for TennCare members with the most significant behavioral health needs. THL is built to encourage the integration of physical and behavioral health, as well as mental health recovery, giving every individual a chance to reach his or her full potential for living a rewarding and increasingly independent life in the community. TDMHSAS and the majority of Community Mental Health Centers (CMHCs) within the state are THL providers. TDMHSAS has worked and will continue to work closely with TennCare and the provider network as this comprehensive integration effort is fully implemented.

Integrated care is promoted through the My Health, My Choice, My Life program. This program is a peer-led health promotion and wellness initiative for Tennesseans who live with mental health and substance use conditions. The holistic health initiative integrates a medical model with recovery and resiliency, resulting in an initiative that focuses on overcoming physical and mental health symptoms through strengths, personal empowerment and resiliency. It is led by peer wellness coaches who have firsthand, lived experience with mental health and substance use disorders and are employed by community mental health providers. My Health, My Choice, My Life provides individuals with self-directed tools, empowering them with the knowledge, skills and resources to improve their overall well-being and resiliency and live healthy and purposeful lives.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

TDMHSAS continues to provide leadership for advancing integrated systems of care for individuals with co-occurring disorders. This is evident through the department's support of the Tennessee Co-Occurring Disorders Collaborative (TNCODC). This multi-agency effort aims to create a common understanding of the impact and treatment of co-occurring disorders in Tennessee communities. The primary goals of TNCODC includes: (1) to share knowledge about the conditions and available resources, (2) reduce stigma, and (3) accurately direct people to timely and effective prevention, treatment, and support.

The Statewide Peer Wellness Coach and Trainer program supports integrated systems of care. This program provides and coordinates health and wellness, recovery and peer support training, technical assistance, and on-going support to Peer Support Center staff, Community Behavioral Health Center staff and Certified Peer Recovery Specialists, among others. This training and supports assist providers in delivering evidence-based health and wellness programming for people with co-occurring mental and substance use disorders in their communities.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs
   a) ☒Yes ☐No

   and Medicaid
   b) ☒Yes ☐No

4. Who is responsible for monitoring access to M/SUD services by the QHPs?

   The SMI/SED focused services covered under Tennessee's Block Grant funding are ancillary and fill gaps by providing services not covered by insurance. There has been no initiative yet developed that will monitor access to all behavioral health services in Tennessee. The TennCare program supports a comprehensive benefit array that is provided through subcontracts between three Managed Care Organizations (MCOs) and providers in all three grand regions of Tennessee.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state?
   ☒Yes ☐No

6. Do the behavioral health providers screen and refer for:
   a) Prevention and wellness education
      ☒Yes ☐No
   b) Health risks such as
      i) heart disease, ☒Yes ☐No
      ii) hypertension, ☒Yes ☐No
      iii) high cholesterol ☒Yes ☐No
      iv) diabetes ☒Yes ☐No
   c) Recovery supports
      ☒Yes ☐No
7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?
   ☒Yes ☐No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?
   ☒Yes ☐No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

Tennessee is facing the following issues related to the implementation and enforcement of parity provisions.

- *Increasing awareness of the protections that parity provides.*

- *Improving understanding of the requirements of parity and of its protections among key stakeholders, including consumers, providers, employers, insurance issuers, and state regulators.*
- *Increasing the transparency of the compliance process and the support, resources, and tools available to ensure that coverage is in compliance with parity, and concurrently improve the monitoring and enforcement process.*

10. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

Health Disparities

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?
   a) race ☒Yes ☐No
   b) Ethnicity ☒Yes ☐No
   c) gender ☒Yes ☐No
   d) sexual orientation ☒Yes ☐No
   e) gender identity, ☒Yes ☒No
   f) Age? ☒Yes ☐No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use, and outcomes for the above subpopulation?
   ☐Yes ☒No

3. Does the state have a plan to identify, address, and monitor linguistic disparities/language barriers?
   ☒Yes ☐No

4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?
   ☒Yes ☐No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards?
   ☒Yes ☐No

6. Does the state have a budget item allocated to identifying and remediating disparities in behavioral health care?
   ☐Yes ☒No

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Innovation in Purchasing Decisions

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ☒Yes ☐No

2. Which value based purchasing strategies do you use in your state (check all that apply):
   a) ☐ Leadership support, including investment of human and financial resources.
   b) ☒ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
   c) ☐ Use of financial and non-financial incentives for providers or consumers.
   d) ☐ Provider involvement in planning value-based purchasing.
   e) ☐ Use of accurate and reliable measures of quality in payment arrangements.
   f) ☐ Quality measures focus on consumer outcomes rather than care processes.
   g) ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
   h)☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Self-Direction

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds, the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following:

1. Does your state have policies related to self-direction?
   ☐Yes ☒No

2. Are there any concretely planned initiatives in your state specific to self-direction?
   ☐Yes ☒No

   If yes, describe the current or planned initiative. In particular, please answer the following questions:

   a. How is the initiative financed?

   b. What are the eligibility criteria?

   c. How are budgets set, and what is the scope of the budget?

   d. What role, if any, do peers with lived experience of the mental health system play in the initiative?

   e. What, if any, research and evaluation activities are connected to the initiative?

   f. If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

Program Integrity

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following:

1) Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ☒Yes ☐No

2) Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? ☒Yes ☐No

3) Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Primary Prevention

The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** *providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;*
2. ***Education*** *aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;*
3. ***Alternative programs*** *that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;*
4. ***Problem identification*** *and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;*
5. ***Community-based processes*** *that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and*
6. ***Environmental strategies*** *that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.*

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following questions:

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)?
   a) ☒Yes ☐No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply):
   a) ☒Data on consequences of substance-using behaviors
   b) ☒Substance-using behaviors
   c) ☒Intervening variables (including risk and protective factors)
   d) ☐Other (please list :)

3. Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups? (check all that apply):

a) ☐Children (under age 12)
b) ☒Youth (ages 12-17)
c) ☒Young adults/college age (ages 18-26)
d) ☒Adults (ages 27-54)
e) ☒Older adults (age 55 and above)
f) ☒Cultural/ethnic minorities
g) ☒Sexual/gender minorities
h) ☒Rural communities
i) ☒Other (please list :) Veterans

4. Does your state use data from the following sources in its primary prevention needs assessment? (check all that apply):
a) ☐Archival indicators (Please list :)

b) ☒National Survey on Drug Use and Health (NSDUH)
c) ☒Behavioral Risk Factor Surveillance System (BRFSS)
d) ☒Youth Risk Behavior Surveillance System (YRBS)
e) ☐Monitoring the Future
f) ☐Communities that Care
g) ☐State-developed survey instrument)
h) ☒Other (please list :) Alcohol Epidemiological Data Systems (AEDS), TN Department of Safety and Homeland Security (TDSHS), Fatality Analysis Reporting System (FARS), TN bureau of Investigations, N Crime Online Website (TBI), Tennessee Council of Juvenile and Family Court Judges (TCJFCJ), TN Department of Mental Health and Substance Abuse Services, 2016 Tennessee Behavioral Health County and Region Services Data Book, TN Bureau of Investigations Lab Data, TN Department of Health, Division of Policy, Planning, and Assessment, Hospital Discharge Data System (HDDS), Neonatal Abstinence Syndrome Surveillance Annual Report 2015, TN Department of Health, Division of Family Health and Wellness (FHW), CDC Wonder, TN Department of Health, Controlled Substance Monitoring Database.

5. Does your state use needs assessment data to make decisions about the allocation of SABG primary prevention funds?
a) ☒Yes ☐No
i) If yes, (if yes, please explain
Data on consumption patterns, consequences of use, and risk and protective factors are reviewed to formulate a prevention strategic plan that clearly articulates which substances should be targeted and incorporates this information into contracts with coalitions and other grantees. In addition, the State requires each funded agency and coalition to review the data available at the local level and conduct the Strategic Prevention Framework (SPF).

ii) If no, please explain how SABG funds are allocated:

Capacity Building

6. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce?
   a) ☒Yes (if yes, please describe)
   The Tennessee Certification Board is a statewide entity funded to strengthen the prevention workforce. This entity administers the International Certification and Reciprocity Consortium's Prevention Specialist certification program and helps ensure a high level of prevention competency among the prevention workforce. Every agency funded with prevention block grant dollars is contractually required to have at least one person on staff that has obtained the IC&RC Prevention Specialist credential.
   b) ☐No

7. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce?
   a) ☒Yes (if yes, please describe mechanism used)
   The Tennessee Association of Alcohol and other Drug Abuse Services (TAADAS) is funded to provide training and resources to the prevention workforce. Training topics are identified through an annual survey. TAADAS has begun using the regional prevention advisory council meetings as a venue to conduct prevention specific trainings. These training events are conducted either before or after the regional meetings and the content of the training event is determined by the prevention providers in the region and are consistent with their organizational needs. DSAS also provides online prevention training and requires that each agency funded with block grant dollars complete two courses each year. These courses have been designed by prevention experts and address the latest in prevention research and science.

   The Prevention Alliance of Tennessee (PAT) is a coalition of coalitions funded by the State. This group represents all of the prevention coalitions within Tennessee, both those funded by the State as well as those coalitions who are not funded. The PAT allows coalitions in Tennessee to speak with a collective voice related to prevention issues in the State. The PAT has developed committees that develop white papers around topics important to the prevention system (i.e. marijuana legalization, prescription drug policies, etc.). Additionally, the PAT provides training and technical assistance to coalitions across the State.

   DSAS has also worked to ensure that the state prevention office is well grounded in prevention science. All state prevention staff members have participated in the Substance Abuse Prevention Skills Training and staff regularly participates in conferences to best understand the latest in prevention science. Additionally, staff works to ensure that providers have the tools they need to 1. Ensure that the locations of all permanent prescription drop boxes are communicated to coalitions; 2. Work with other State Departments to design a workable plan; and 3. Incinerate substances. The Office of

Prevention Services tries to expand the capacity of coalitions and other providers by providing resources that are timely and meet identified needs. We have started offering annual face-to-face provider meetings where contract requirements are reviewed, but there is also a training component. Also, we are working with Strategic Answers and the National Guard to provide technical assistance to coalitions that best meet their needs.

DSAS is also working collaboratively with the National Guard, Counter Drug Task Force; Civil Operations Unity to provide well-trained and adaptable forces capable of developing anti-drug coalitions while implementing effective prevention practices. Their vision is to be the preferred source for Technical Assistance for coalitions across the state and for all state agencies involved with the development and training of prevention coalitions by being a force multiplier in a coalition's pursuit to drive positive environmental change in their community and continuously seeking new opportunities to develop effective grassroots coalitions in communities without a drug preventative organization.

b) ☐No

8. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?
   a) ☒Yes (if yes, please describe mechanism used :)

   b)☐ No

Planning

9. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years?
   a) ☐Yes (If yes, please attach the plan in BGAS)
   b) ☒No

10. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG?
    a) ☐Yes ☒No
       ☒Not applicable (no prevention strategic plan)

11. Does your state's prevention strategic plan include the following components? (check all that apply):
    a) ☐Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
    b) ☐Timelines
    c) ☐Roles and responsibilities
    d) ☐Process indicators

e) ☐Outcome indicators
f) ☐Cultural competence component
g) ☐Sustainability component
h) ☐Other (please list:)

i) ☒Not applicable/no prevention strategic plan

12. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?
    a) ☒Yes ☐No

13. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?
    a) ☒Yes ☐No
    b) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?
    Inclusion in NREPP and other federal listing of evidence based approaches. The EBPW is in the process of reviewing current training materials and work plan worksheets with TDMHSAS to see what gaps might need to be addressed in lit review. Additionally, they will create a deliverable to help coalitions better understand theories of change.

    The State working with its Evidence-Based Practice Workgroup (EBPW) and hopes to accomplish the following under the new structure:
    - Conduct research into health disparities and environmental strategies that are evidence-based for alcohol and establish correlates for impacts on other substances of abuse (e.g. prescription drugs);
    - Conduct discussion groups with coalition staff regarding program implementation to ensure that work products align with evidence based practices;
    - Develop fidelity models for environmental practices for a variety of substances of abuse;
    - Conduct presentations for coalitions and other groups to describe research and make relevant at the practice level; and
    - Develop a menu of evidence-based practices and cite relevant research.

Implementation

14. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

a) ☒SSA staff directly implements primary prevention programs and strategies.
b) ☒The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
c) ☒The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.

d) ☒The SSA funds regional entities that provide training and technical assistance.
e) ☒The SSA funds regional entities to provide prevention services.
f) ☐The SSA funds county, city, or tribal governments to provide prevention services.
g) ☒The SSA funds community coalitions to provide prevention services.
h) ☒The SSA funds individual programs that are not part of a larger community effort.
i) ☐The SSA directly funds other state agency prevention programs.
j) ☐Other (please describe)

15. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

- Tennessee Prevention Network
- School Based Liaisons
- Redline and Clearinghouse
- Workforce Training Program
- Community Based Coalitions
- In-Home Visitation Services for At-Risk Mothers
- SAPT Evidence Based Practices Workgroup

b) Education:

- Tennessee Prevention Network
- School Based Liaisons
- Workforce Training Program
- Community Based Coalitions
- In-Home Visitation Services for At-Risk Mothers

c) Alternatives:

- Tennessee Prevention Network
- Community Based Coalitions
- Higher Education Coalition

d) Problem Identification and Referral:

- Tennessee Prevention Network
- School Based Liaisons
- Tennessee Prevention Network
- Redline and Clearinghouse
- In-Home Visitation Services for At-Risk Mothers
- SAPT Evidence Based Practices Workgroup

The In-Home Visitation Services for At-Risk Mothers provides in-home visitation services to improve pregnancy outcomes and ensure the health, growth and development of

infants most at-risk. The program's goal is to improve the health status of women and children by reducing the use and misuse of tobacco, alcohol, and other substances and to increase the early identification and management of maternal depression. These services will be provided from pregnancy until the infant's second birthday.

The School Based Mental Health Liaison service provides primary prevention services to youth and their parents or guardians. Liaisons are hired to assist school staff in enhancing the classroom learning environment and provide training around a variety of mental health and substance abuse topics. The Liaison services utilize the CSAP strategies of information dissemination, prevention education, and problem identification and referral. Services are provided in each of the three grand divisions of the State.

e) Community-Based Processes:

- Tennessee Prevention Network
- Community Based Coalitions
- Higher Education Coalition
- SAPT Evidence Based Practices Workgroup

e) Environmental:

- School Based Liaisons
- Community Based Coalitions

16. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?
    a) ☒Yes (if so, please describe:)

DSAS ensures that SABG dollars are used to fund primary substance abuse prevention services by including language within prevention contracts that defines "primary prevention" and explicitly stating that prevention funding can only be used for primary prevention. Additionally, training is provided each year to ensure agencies understand the requirement; and agencies are monitored against their contract during regularly scheduled monitoring visits. The Tennessee Department of Mental Health and Substance Abuse Services conduct programmatic and fiscal monitoring visits on all providers at least once over a three year period. Programmatic monitoring visits assess achievement of contract performance benchmarks through the examination of personnel and service recipient records and data management as well as evaluation of conformity with agency policies and procedures and DSAS requirements. The fiscal monitoring visit is conducted in accordance to the Tennessee Department of General Services Policy 2013-007, Subrecepient Monitoring. The objectives for the fiscal review include a test to determine if costs and services are allowable and eligible; and to verify contractual compliance. In addition, there is a special term and condition in all grant contracts prohibiting supplanting of SABG funds.

b) ☐No

Evaluation

17. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years?
    a) ☐Yes (If yes, please attach the plan in BGAS)
    b) ☒No

18. Does your state's prevention evaluation plan include the following components? (check all that apply):
    a) ☐Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
    b) ☐Includes evaluation information from sub-recipients
    c) ☐Includes SAMHSA National Outcome Measurement (NOMs) requirements
    d) ☐Establishes a process for providing timely evaluation information to stakeholders
    e) ☐Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
    f) ☐Other (please describe:)

    g) ☒Not applicable/no prevention evaluation plan

19. Please check those process measures listed below that your state collects on its SABG funded prevention services:
    a) ☒Numbers served
    b) ☒Implementation fidelity
    c) ☐Participant satisfaction
    d) ☒Number of evidence based programs/practices/policies implemented
    e) ☒Attendance
    f) ☒Demographic information
    g) ☐Other (please describe:)

20. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:
    a) ☐30-day use of alcohol, tobacco, prescription drugs, etc...
    b) ☐Heavy use Binge use Perception of harm
    c) ☐Disapproval of use
    d) ☐Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
    e) ☒Other (please describe:)

Substance Use Disorder Treatment

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs.

Improving access to treatment services

1. Does your state provide:
   a) A full continuum of services:
      i) Screening
      ☒**Yes** ☐**No**
      ii) Education
      ☒**Yes** ☐**No**
      iii) Brief intervention
      ☒**Yes** ☒**No**
      iv) Assessment
      ☒**Yes** ☐**No**
      v) Detox (inpatient/social)
      ☒**Yes** ☐**No**
      vi) Outpatient
      ☒**Yes** ☐**No**
      vii) Intensive outpatient
      ☒**Yes** ☐**No**
      viii) Inpatient/residential
      ☒**Yes** ☐**No**
      ix) Aftercare; recovery support
      ☒**Yes** ☐**No**

   b) Are you considering any of the following:
      Targeted services for veterans
      ☐**Yes** ☒**No**

   c) Expansion of services for:
      (1) Adolescents
         (a) ☐**Yes** ☒**No**
      (2) Older adults
         (a) ☐**Yes** ☒**No**
      (3) Medication-Assisted Treatment (MAT)
         (a) ☒**Yes** ☐No

Criterion2: Improving Access and Addressing Primary Prevention – see Section 8
This should say Narrative 9 Primary Prevention

Criterion 3: Pregnant Women and Women with Dependent Children (PWWDC)

1. Does your state meet the performance requirement to establish and or maintain new programs or expand programs to ensure treatment availability?
   a) ☒**Yes** ☐**No**
2. Either directly or through an arrangement with public or private nonprofit entities make prenatal care available to PWWDC receiving services?
   a) ☒**Yes** ☐**No**
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?
   a) ☒**Yes** ☐**No**
4. Does your state have an arrangement for ensuring the provision of required supportive services?
   a) ☒**Yes** ☐**No**
5. Are you considering any of the following:
   a) Open assessment and intake scheduling
      ☐**Yes** ☒**No**
   b) Establishment of an electronic system to identify available treatment slots
      ☒**Yes** ☐**No**
   c) Expanded community network for supportive services and healthcare
      ☐**Yes** ☒**No**
   d) Inclusion of recovery support services
      ☒**Yes** ☐**No**
   e) Health navigators to assist clients with community linkages
      ☒**Yes** ☐**No**
   f) Expanded capability for family services, relationship restoration, custody issue
      ☒**Yes** ☐**No**
   g) Providing employment assistance
      ☒**Yes** ☐**No**
   h) Providing transportation to and from services
      ☒**Yes** ☐**No**
   i) Educational assistance
      ☐**Yes** ☒**No**
6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   Monitoring program compliance is a contractual requirement for all funded providers.

   <u>Monitoring</u>. In accordance with Section D.16., the State shall conduct program monitoring as follows:

   (1) State monitors shall notify the Grantee of their arrival, prior to site visit inception. The Grantee shall make available all relevant personnel on the appointed day and at the scheduled time chosen by the State, unless otherwise arranged with the State.

Deviations from the proposed site visit date must be approved by the State no later than two (2) weeks prior to the site visit date;

(2) The Grantee shall comply with any and all requests for information as issued by the State and is required to have all information slated for review, present and ready for review on the appointed day and at the scheduled time of the review. All requested information is to be prepared as specified by the State;

(3) Following the monitoring visit or desk review, the Grantee shall receive a Monitoring Report. If the Monitoring Report indicates that the Grantee has incurred reportable findings, the Grantee shall be required to submit a Corrective Action Plan (CAP) for the State's approval. The CAP must include the date issued, the signature of the preparer, and must address each reportable finding listed in the Monitoring Report. The CAP must also include corrective action to be implemented, person responsible for implementing corrective action, and the CAP implementation date;

(4) Grantee correspondence concerning the CAP may be submitted to the State in hard copy or electronically, as an attachment, via electronic mail (e-mail); and must include a cover letter on Grantee letterhead; and must conform to the State approved format; and must be submitted within the timeframe specified by the State. No facsimile CAP information will be accepted; and

(5) If the CAP is satisfactory, the Grantee shall receive a CAP Approval Letter from the State. If the CAP is unsatisfactory, the Grantee shall receive a CAP Disapproval Letter requesting amendment and resubmission to the State. After the CAP is approved, the State shall conduct a follow-up site visit within sixty (60) days after the approval of the CAP. It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Grant Contract as specifically indicated herein.

Criterion 4, 5 and 6: Persons Who Inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the
   a) 90 percent capacity reporting requirement
      ☒**Yes** ☐**No**
   b) 14-120 day performance requirement with provision of interim services
      ☒**Yes** ☐**No**
   c) Outreach activities
      ☒**Yes** ☐**No**
   d) Syringe services programs
      ☐**Yes** ☒**No**

e) Monitoring requirements as outlined in the authorizing statute and implementing regulation

☒**Yes** ☐**No**

2. Are you considering any of the following:

a) Electronic system with alert when 90 percent capacity is reached

☒**Yes** ☐**No**

b) Automatic reminder system associated with 14-120 day performance requirement

☐**Yes** ☒**No**

c) Use of peer recovery supports to maintain contact and support

☒**Yes** ☐**No**

d) Service expansion to specific populations (military families, veterans, adolescents, older adults)

☒**Yes** ☐**No**

3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Monitoring program compliance is a contractual requirement for all funded providers.

Monitoring. In accordance with Section D.16., the State shall conduct program monitoring as follows:

(1) State monitors shall notify the Grantee of their arrival, prior to site visit inception. The Grantee shall make available all relevant personnel on the appointed day and at the scheduled time chosen by the State, unless otherwise arranged with the State. Deviations from the proposed site visit date must be approved by the State no later than two (2) weeks prior to the site visit date;

(2) The Grantee shall comply with any and all requests for information as issued by the State and is required to have all information slated for review, present and ready for review on the appointed day and at the scheduled time of the review. All requested information is to be prepared as specified by the State;

(3) Following the monitoring visit or desk review, the Grantee shall receive a Monitoring Report. If the Monitoring Report indicates that the Grantee has incurred reportable findings, the Grantee shall be required to submit a Corrective Action Plan (CAP) for the State's approval. The CAP must include the date issued, the signature of the preparer, and must address each reportable finding listed in the Monitoring Report. The CAP must also include corrective action to be implemented, person responsible for implementing corrective action, and the CAP implementation date;

(4) Grantee correspondence concerning the CAP may be submitted to the State in hard copy or electronically, as an attachment, via electronic mail (e-mail); and must include a cover letter on Grantee letterhead; and must conform to the State approved format; and must be submitted within the timeframe specified by the State. No facsimile CAP information will be accepted; and

(5) If the CAP is satisfactory, the Grantee shall receive a CAP Approval Letter from the State. If the CAP is unsatisfactory, the Grantee shall receive a CAP Disapproval Letter requesting amendment and resubmission to the State. After the CAP is approved, the State shall conduct a follow-up site visit within sixty (60) days after the approval of the CAP. It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Grant Contract as specifically indicated herein.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?

☒**Yes** ☐**No**

2. Are you considering any of the following:

a) Business agreement/MOU with primary healthcare providers

☐**Yes** ☒**No**

b) Cooperative agreement/MOU with public health entity for testing and treatment

☒**Yes** ☐**No**

c) Established co-located SUD professionals within FQHCs

☐**Yes** ☒**No**

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Monitoring program compliance is a contractual requirement for all funded providers.

Monitoring. In accordance with Section D.16., the State shall conduct program monitoring as follows:

(1) State monitors shall notify the Grantee of their arrival, prior to site visit inception. The Grantee shall make available all relevant personnel on the appointed day and at the scheduled time chosen by the State, unless otherwise arranged with the State. Deviations from the proposed site visit date must be approved by the State no later than two (2) weeks prior to the site visit date;

(2) The Grantee shall comply with any and all requests for information as issued by the State and is required to have all information slated for review, present and ready for review on

the appointed day and at the scheduled time of the review. All requested information is to be prepared as specified by the State;

(3) Following the monitoring visit or desk review, the Grantee shall receive a Monitoring Report. If the Monitoring Report indicates that the Grantee has incurred reportable findings, the Grantee shall be required to submit a Corrective Action Plan (CAP) for the State's approval. The CAP must include the date issued, the signature of the preparer, and must address each reportable finding listed in the Monitoring Report. The CAP must also include corrective action to be implemented, person responsible for implementing corrective action, and the CAP implementation date;

(4) Grantee correspondence concerning the CAP may be submitted to the State in hard copy or electronically, as an attachment, via electronic mail (e-mail); and must include a cover letter on Grantee letterhead; and must conform to the State approved format; and must be submitted within the timeframe specified by the State. No facsimile CAP information will be accepted; and

(5) If the CAP is satisfactory, the Grantee shall receive a CAP Approval Letter from the State. If the CAP is unsatisfactory, the Grantee shall receive a CAP Disapproval Letter requesting amendment and resubmission to the State. After the CAP is approved, the State shall conduct a follow-up site visit within sixty (60) days after the approval of the CAP. It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Grant Contract as specifically indicated herein.

Early Intervention Services for HIV (For "Designated States" Only)

1. Does your state current have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery?

   ☒**Yes** ☐**No**

2. Are you considering any of the following:

   a) Establishment of EIS-HIV service hubs in rural areas

   ☐**Yes** ☒**No**

   b) Establishment or expansion of tele-health and social media support services

   ☐**Yes** ☒**No**

   c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS

   ☐**Yes** ☒**No**

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes (42 U.S.C.§ 300x-31(a)(1)F)?
   ☒**Yes** ☐**No**
2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program
   ☐**Yes** ☒**No**
3. Do any of your programs use SABG funds to support elements of a Syringe Services Program
   a) ☐**Yes** ☒**No**
   b) If yes, please provide a brief description of the elements and the arrangement

Criterion 8, 9 and 10: Service System Needs, Service Coordination, Charitable Choice, Referrals, Patient Records, and Independent Peer Review

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention, and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement?
   ☒**Yes** ☐**No**
2. Are you considering any of the following:
   a) Workforce development efforts to expand service access
   ☐**Yes** ☒**No**
   b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services
   ☐**Yes** ☒**No**
   c) Establish a peer recovery support network to assist in filling the gaps
   ☒**Yes** ☐**No**
   d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)
   ☒**Yes** ☐**No**
   e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations
   ☐**Yes** ☒**No**
   f) Explore expansion of services for:
      i) MAT
      (1) ☒**Yes** ☐**No**
      ii) Tele-health
      (1) ☐**Yes** ☒**No**
      iii) Social media outreach
      (1) ☒**Yes** ☐**No**

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?

☐**Yes** ☒**No**

2. Are you considering any of the following:

a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services

☐**Yes** ☒**No**

b) Establish a program to provide trauma-informed care

☒**Yes** ☐**No**

c) Identify current and perspective partners to be included in building a system of care, e.g., FQHCs, primary healthcare, recovery community organizations, juvenile justice system, adult criminal justice system, and education

☒**Yes** ☐**No**

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)

☒**Yes** ☐**No**

2. Are you considering any of the following:

a) Notice to Program Beneficiaries

☒**Yes** ☐**No**

b) Develop an organized referral system to identify alternative providers

☒**Yes** ☐**No**

c) Develop a system to maintain a list of referrals made by religious organizations

☒**Yes** ☐**No**

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs

☒**Yes** ☐**No**

2. Are you considering any of the following:

a) Review and update of screening and assessment instruments

☐**Yes** ☒**No**

b) Review of current levels of care to determine changes or additions

☐**Yes** ☒**No**

c) Identify workforce needs to expand service capabilities

☒**Yes** ☐**No**

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background

☒**Yes** ☐**No**

Patient Records

1. Does your state have an agreement to ensure the protection of client records
   a) ☒**Yes** ☐**No**
2. Are you considering any of the following:
   a) Training staff and community partners on confidentiality requirements
   ☐**Yes** ☒**No**
   b) Training on responding to requests asking for acknowledgement of the presence of clients
   ☐**Yes** ☒**No**
   c) Updating written procedures which regulate and control access to records
   ☐**Yes** ☒**No**
   d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure
   ☐**Yes** ☒**No**

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers
   a) ☒**Yes** ☐**No**

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.
a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved

A minimum of 2 agencies will received an independent peer review each fiscal year for a total of 4.

3. Are you considering any of the following:
   a) Development of a quality improvement plan
   ☐**Yes** ☒**No**
   b) Establishment of policies and procedures related to independent peer review
   ☐**Yes** ☒**No**
   c) Develop long-term planning for service revision and expansion to meet the needs of specific populations
   ☐**Yes** ☒**No**

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?

a) ☐**Yes** ☒**No**

b) If Yes, please identify the accreditation organization(s)

i) ☐Commission on the Accreditation of Rehabilitation Facilities

ii) ☐The Joint Commission

iii) ☐Other (please specify)

Criterion 7 and 11: Group Homes for Persons In Recovery and Professional Development

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?

☒**Yes** ☐**No**

2. Are you considering any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service

☒**Yes** ☐**No**

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing

☐**Yes** ☒**No**

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state

☒**Yes** ☐**No**

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services

☒**Yes** ☐**No**

c) Performance-based accountability

☐**Yes** ☒**No**

d) Data collection and reporting requirements

☒**Yes** ☐**No**

2. Are you considering any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs

☒**Yes** ☐**No**

b) Addition of training sessions designed to increase employee understanding of recovery support services

☐**Yes** ☒**No**

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services

☒**Yes** ☐**No**

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort

☒**Yes** ☐**No**

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924 and 1928 (42 U.S.C. § 300x-32(f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations Regarding Women

☐**Yes** ☒**No**

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus

a) Tuberculosis

☐**Yes** ☒**No**

b) Early Intervention Services Regarding HIV

☐**Yes** ☒**No**

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment

☐**Yes** ☒**No**

b) Professional Development

☐**Yes** ☒**No**

c) Coordination of Various Activities and Services

☐**Yes** ☒**No**

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.

Rules of the Tennessee Department of Mental Health and Substance Abuse Services
http://share.tn.gov/sos/rules/0940/0940-05/0940-05.htm

Tennessee Code Annotated Title 33, Chapter 10
http://www.lexisnexis.com/hottopics/tncode/

Quality Improvement Plan

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

1. Has your state modified its CQI plan from FFY 2016-FFY 2017?
a) ☐Yes ☒No

Please indicate areas of technical assistance needed related to this section.

Trauma

Trauma is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.
It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma paper.
Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues? ☒Yes ☐No
2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers?
   ☒Yes ☐No
3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care?
   ☐Yes ☒No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?
   ☒Yes ☐No
5) Does the state have any activities related to this section that you would like to highlight.
   All DSAS funded providers are required to provide a screening and assessment for trauma and ensure that the treatment plan addresses the trauma. The provider can use the AC-OK Adult Screen for trauma or another trauma screen from the SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) on each service recipient upon initial contact. The provider is also required to complete a brief trauma screener in the Tennessee Web-based Informational Technology System if trauma is identified during the administration of the ASI.

Please indicate areas of technical assistance needed related to this section.

Criminal and Juvenile Justice

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.
The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.
Please respond to the following items:

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services?

   ☒Yes ☐No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?

   ☒Yes ☐No

3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

   ☒Yes ☐No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances?

   ☒Yes ☐No

5. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Medication Assisted Treatment

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?
   ☒Yes ☐No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women?
   ☒Yes ☐No

3. Does the state purchase any of the following medication with block grant funds?
   a) ☐Methadone
   b) ☒Buprenorphine; Buprenorphine/naloxone
   c) ☐Disulfiram
   d) ☐Acamprosate
   e) ☐Naltrexone (oral, IM)
   f) ☐Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance use disorders are used appropriately*?
   ☒Yes ☐No

5. Does the state have any activities related to this section that you would like to highlight?

*Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychosocial treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.

Crisis Services

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

1. Crisis Prevention and Early Intervention
   a) ☒Wellness Recovery Action Plan (WRAP) Crisis Planning
   b) ☒Psychiatric Advance Directives
   c) ☒Family Engagement
   d) ☒Safety Planning
   e) ☒Peer-Operated Warm Lines
   f) ☐Peer-Run Crisis Respite Programs
   g) ☒Suicide Prevention

2. Crisis Intervention/Stabilization:
   a) ☒Assessment/Triage (Living Room Model)
   b) ☐Open Dialogue
   c) ☒Crisis Residential/Respite
   d) ☒Crisis Intervention Team/ Law Enforcement
   e) ☒Mobile Crisis Outreach
   f) ☒Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support:
   a) ☒WRAP Post-Crisis
   b) ☒Peer Support/Peer Bridgers
   c) ☒Follow-Up Outreach and Support
   d) ☒Family-to-Family engagement
   e) ☒Connection to care coordination and follow-up clinical care for individuals in crisis
   f) ☒Follow-up crisis engagement with families and involved community members
   g) ☐Recovery community coaches/peer recovery coaches
   h) ☐Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Recovery

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:
   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?
   ☒Yes ☐No

   b) Required peer accreditation or certification?
   ☒Yes ☐No

   c) Block grant funding of recovery support services.
   ☒Yes ☐No

   d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?
   ☒Yes ☐No

2. Does the state measure the impact of your consumer and recovery community outreach activity?
   ☐Yes ☒No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.
   Not applicable

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.
   Recovery Support Services are provided to people in recovery to promote individual, program, and system-level approaches that foster health and resilience, increase permanent housing, employment and other necessary supports, and reduce barriers to social inclusion.

5. Does the state have any activities that it would like to highlight?

Tennessee added Recovery Activities to its recovery array of services. Providers are now able to bill for activities that assist a service recipient in his or her recovery process. Recovery activities can include cultural activities, community events, and other similar activities.

Please indicate areas of technical assistance needed related to this section.

Children and Adolescents Behavioral Health Services

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- *non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);*
- *supportive services, (Wee.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and*
- *residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).*

Please respond to the following:

1. Does the state utilize a system of care approach to support:
   a) The recovery and resilience of children and youth with SED?
      ☒Yes ☐No
   b) The recovery and resilience of children and youth with SUD?
      ☒Yes ☐No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs
   a) Child welfare?
      ☒Yes ☐No
   b) Juvenile justice?
      ☒Yes ☐No
   c) Education?
      ☒Yes ☐No

3. Does the state monitor its progress and effectiveness, around:
   a) Service utilization?
      ☒Yes ☐No
   b) Costs?
      ☒Yes ☐No
   c) Outcomes for children and youth services?
      ☒Yes ☐No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?

☒Yes ☐No

b) Mental health treatment and recovery services for children/adolescents and their families?

☒Yes ☐No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult behavioral health system?

☒Yes ☐No

b) for youth in foster care?

☒Yes ☐No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

Tennessee provides integrated services through partnerships that have been developed throughout the state since the adoption of System of Care in 1999. The System of Care in Tennessee is governed by the legislatively mandated Council on Children's Mental Health (CCMH), which brings together individuals from across the state to discuss systems, projects, and programs that touch the lives of children and youth with mental health concerns. CCMH provides a venue, five times annually, for child serving agencies to discuss current trends within the state as well as potential barriers to service. The council has various ad hoc committees that identify and problem-solve issues around financing, policy, community readiness, marketing, and other areas related to the promotion of System of Care across Tennessee. In addition to CCMH, there are numerous advisory boards, councils, and committees on which System of Care is represented to work toward improving the lives of young children, children, youth, young adults, and families across the state including: the Youth Transition Advisory Council, Healthy Transitions State Transition Team, and the Young Child Wellness Council. System of Care in Tennessee is beginning training on the use of high fidelity wraparound which will further integrate services by providing wraparound services to children and families by bringing together systems to work toward a single treatment plan among child-serving agencies. Several of our children and youth programs offer integrated services at the local level by working with schools, the juvenile justice system, and child welfare services.

7. Does the state have any activities related to this section that you would like to highlight?

Through the Treatment Recovery for Youth grant, (SAMHSA Cooperative Agreements for State Adolescent and Transitional Aged Youth Treatment Enhancement and Dissemination Implementation), Tennessee provided Adolescent Community Reinforcement Approach (A-CRA) training for adolescents and young adults. This evidence based model includes sessions for both the youth as well as their parents/significant others and encourages in home sessions for individuals that are unable to travel to a treatment provider.

Please indicate areas of technical assistance needed related to this section.

Public Comment on the State Plan

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
   a) Public meetings or hearings?
      ☐Yes ☒No
   b) Posting of the plan on the web for public comment?
      ☒Yes ☐No
   c) Other (e.g. public service announcements, print media)
      ☒Yes ☐No

      if yes, provide URL
      http://www.tn.gov/behavioral-health

      Public comment for the SABG is solicited through both public availability and direct distribution of the draft plan to members of the Tennessee Department of Mental Health Planning and Policy Council, substance abuse prevention and treatment contract providers, TDMHSAS executive staff, any other individuals or organizations requesting access and the general public.

      Copies of the FY 2018-2019 Block Grant draft application was e-mailed to members of the groups mention above and a link was posted on the Tennessee Web-based Information Technology System and Department's website homepage for general public access, review and comment during the development of the plan and submission to HHS. Comments were directed to the Block Grant Coordinator; although comments could also be directed to either the Council Chair or Department Commissioner.